PERSONAL AND MEDICAL DATA FORM (child/ adolescent)

Child/ Adolescent's name _____ Today's date _____

Date of birth _____ Age _____ Gender_____ Ethnicity _____

Biological parents: ___ Married ____ Divorced ___ Widowed ____ other: _____

If parents are divorced, what is the **legal** custody? (circle) Joint Mother has sole Father has sole

Persons living in child's main household:_____
If applicable, persons living in child's 2nd household: _____

Specific Reason for evaluation: _____

Do you have any of the following concerns about your child? ___ Anxiety ___ Depression ___ Anger
____ Doing poorly in school ____ Eating (i.e. anorexia/ bulimia) _____ social concerns ____defiance
____ Drugs/ alcohol ___ dramatic mood swings ___ poor attention span _____ hyperactivity
____ psychosis (i.e. hallucinations) _____ cruelty to animals/ people ____ family issues

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DEVELOPMENTAL/ MEDICAL HISTORY

Age of mother at child's birth: _____ Any problems with the pregnancy/ delivery? _____
Describe any exposure to drugs/ alcohol/ medications during pregnancy? _____
Was child healthy at birth and during infancy? _____

Were developmental milestones achieved by the time listed? (check if yes)

Sitting by 9 months _____ Walking by 15 months _____ Toilet training by 4 years _____
Talking: Babbling by 9 months _____ Several words by 15mos. _____ 2 word sentences by 3 yrs _____
Understandable by 4 yrs _____ Tying shoes by 6 yrs _____ Riding 2-wheel bike by 7 years _____
Any treatment for speech issues? If yes, what ages? _____Hearing problems? _____
Vision issues? _____Any history of coordination problems / developmental delay? _____
Any history of sensory integration issues? (very sensitive to clothes, noises, etc. to point it interferes with life) _____
Occupational therapy? _____Significant behavioral or emotional problems prior to age 5? _____
Explain any developmental concerns: _____

Has your child ever had any of the following medical problems:

Asthma	____ yes ____ no	Heart problems	____ yes ____ no
Significant allergies	____ yes ____ no	Frequent headaches/migraines	_____ yes ____no
Chronic sleep problems	____ yes ____ no	Seizure/ neurological	____ yes ____ no
Major head injury	____ yes ____ no	Diabetes	____ yes ____ no
Growth problems	____ yes ____ no	Ever been hospitalized	____ yes ____ no
Stomach problems	____ yes ____ no	Tics (eye blinking, etc)	____ yes ____ no

Current medications/dosages
(include vitamins, over the counter, etc) _____

Other significant medical concerns_____

Previous psychiatric medications (and what the med did… any bad reactions?)_____

Medication allergies _____

Does your child have a regular medical provider (pediatrician, etc)? _____ Last visit: _____

Last blood draw: _____ Any history of abnormal lab results? _____

The child/ adolescent is in the room for the entire evaluation. If there's anything you don't want to share in front of them, please tell me here: